

## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Grapevine Surgicare

**Respondent Name**

Indemnity Insurance of North America

**MFDR Tracking Number**

M4-22-0473-01

**Carrier's Austin Representative**

Box Number 15

**DWC Date Received**

November 4, 2021

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 24, 2020	ASC Services C9359	\$3,421.00	\$0.00
December 24, 2020	ASC Services C1713	\$5,619.98	\$0.00
Total		\$7,490.53	\$0.00

### Requestor's Position

This clean claim was billed requesting the surgical procedure be paid at 153% of CMS with separate reimbursement for our implants. **According to Texas Workers Compensation Rule 134.402, "Implantable devices are reimbursed at the providers cost plus 10% up to \$1,000.00 per item or \$2,000.00 per case."**

**Amount in Dispute:** \$7,490.53

### Respondent's Position

Upon receipt of the MDR requested, the bill was sent for reconsideration. A payment of \$5109.07 was issued on 12-2-2021.

**Response Submitted by:** ESIS

## Findings and Decision

### Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

### Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.402 sets out the fee guidelines for ambulatory surgical services.

### Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 881 – This item is an integral part of an emergency room visit or surgical procedure and is therefore included in the reimbursement for the facility/APC rate.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

### Issues

1. Is Grapevine Surgicare entitled to additional reimbursement?

### Findings

1. Grapevine Surgicare is seeking reimbursement for implantables used during surgery performed on December 24, 2020.

Per explanation of benefits dated May 14, 2021, the insurance carrier's denial indicated that the disputed services were included in the reimbursement for the facility/APC rate.

The fee guidelines for disputed services are found in 28 TAC §134.402. Per Addendum AA, CPT codes 27403 is a device intensive procedure. The health care provider requested separate payment for the implantables using HCPCS codes C1713 and C9359.

Grapevine Surgicare is seeking reimbursement only for the implantables billed for this service. These are the services reviewed in this dispute.

A review of the submitted documentation finds the requestor submitted invoices but did not submit a copy of the implant record to support which implants were billed with codes C1713 and C9359; therefore, additional reimbursement cannot be recommended.

### Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor

and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

### Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

### Authorized Signature

_____	_____	February 10, 2022
Signature	Medical Fee Dispute Resolution Officer	Date

### Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at [www.tdi.texas.gov/forms/form20numeric.html](http://www.tdi.texas.gov/forms/form20numeric.html). DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).